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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/09/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: inpatient L4/5, L5/S1 lumbar spinal fusion and inpatient hospital length of stay three (3) days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Neurological Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that the inpatient L4/5, L5/S1 lumbar spinal fusion and inpatient hospital length of stay three (3) days is medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on xx/xx/xx. the patient developed complaints of low back pain. This became more severe despite prior physical therapy or injections. These included epidural steroid injections as well as facet injections. The patient had no long term relief with medications including Hydrocodone and anti-inflammatories. The patient was being followed for persistent complaints of low back pain. The patient did describe some radiating pain from the buttock to the knees with associated numbness and tingling. In order to determine the patient's pain generators the patient was referred for lumbar discography. This was completed on 01/21/15. Per the report, discography was performed at L3-4, L4-5, and at L5-S1. Concordant pain was reproduced at both the L4-5 and L5-S1 levels. Post-discogram CT study dated 01/21/15 noted a mild disc bulge at L4-5 measuring 2mm with facet arthrosis contributing to mild foraminal narrowing without canal stenosis. At L5-S1, there was disc sclerosis and disc bulging measuring 2.5mm with facet arthrosis without foraminal or canal stenosis. Due to osteophytes laterally, there was approximation of the exiting L5 nerve roots.

The patient was seen on 03/02/15 with continuing complaints of low back pain despite medications, physical therapy, and injections. The patient's physical examination noted limited lumbar range of motion with mild tenderness to palpation. No focal neurological deficits were evident. Per the appeal letter on 03/03/15, the patient was psychologically screened who found no contraindications for surgical intervention.

The requested L4-5 and L5-S1 lumbar fusion was denied previously on 02/19/15 as there were no updated MRI studies available for review and discography studies alone were a poor indicator for lumbar fusion.

The requests were again denied on 03/17/15 due to the limited evidence of neurological

compromise on exam and imaging to support decompression procedures.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for chronic complaints of low back pain without any focal neurological deficits that has failed conservative treatment to include injections, multiple medications, as well as physical therapy. Based on most recent clinical report on 03/02/15, the patient was felt to have functional unit failure at L4-5 and L5-S1 with spondylitic disease confirmed as pain generators by 2 level discogram studies completed on 01/21/15. The discogram study on 01/21/15 reproduced concordant low back pain at both L4-5 and at L5-S1. Post-discogram CT studies of the lumbar spine did note 2 level degenerative disc disease and facet arthropathy at L4-5 and L5-S1. At this point, failure of conservative treatment has been established and the patient does have concordant pain evident on discography. Per the current literature, for very carefully selected patients, lumbar spinal fusion can be a method of last resort for improving function and reducing pain. Guidelines would recommend a psychosocial evaluation to rule out any confounding issues that could possibly impact postoperative recovery. Per appeal letter on 03/03/15, this was performed who found no contraindications for surgical intervention. At this point in time, the clinical documentation submitted for review would meet guideline recommendations regarding the proposed surgical procedures. Therefore, medical necessity for the L4-5 and L5-S1 lumbar fusion is established. There would be a requirement for a postoperative inpatient stay for monitoring and recovery. The 3 day inpatient stay request would be within guideline recommendations. Therefore, it is this reviewer's opinion that the inpatient L4/5, L5/S1 lumbar spinal fusion and inpatient hospital length of stay three (3) days is medically necessary and the prior denials are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)